

Exact statement of OCCUPATION is very important.

REC'D FEB 9 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

3377  
Do not use this space.

1. PLACE OF DEATH

(a) County Jennison Registration District No. 65-1  
(b) Township 1 Primary Registration District No. 4388 Registered No. 8  
(c) City Couthersville (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 1325 Rosa Lee Perkins East 13th St. \_\_\_\_\_ St. \_\_\_\_\_  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female  
4. COLOR OR RACE Black  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-6-1921  
7. AGE YEARS 17 MONTHS 7 DAYS 16 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Unknown  
9. Industry or business in which work was done, as saw mill, bank, etc. Housework  
10. Date deceased last worked at this occupation (month and year) Unknown  
11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jennison

FATHER 13. NAME Will Perkins

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Willie Fisher

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Luther Boyd  
Couthersville, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Morgan Valley STATE Mo

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. Smith  
Couthersville, Mo

20. FILED Jan. 24, 1939 Leda Motter  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-22-1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.  
I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 6 p m.  
The principal cause of death and related causes of importance were as follows:

unknown  
(No Physician)  
Date of onset \_\_\_\_\_

Other contributory causes of importance: 20012

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_  
(Signed) W. Smith, M. D.  
Physician  
585 (Address) \_\_\_\_\_

RECEIVED

District Health Officer N

District File Number 39-1

Date Filed 2-7-99

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, \_\_\_\_\_, or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed Neil C. Dean

Licensed Embalmer No. 3941

P. O. Address Courthouseville, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**